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ABSTRACT

This booklet is about the Mothers Inform Mothers program (MIM), a network of local early childhood care and development support programs in five provinces in The Netherlands. These programs are carried out in eight different towns (two large, four medium, and two small) in deprived areas. A short overview of the theoretical basis for the program is given, including health promotion, social support, nursing, and community organization. Planning, execution, and process evaluation activities are also discussed. The purpose of the booklet is to give information about MIM to an international audience. The booklet is aimed at professionals such as nurses, medical practitioners, developmental psychologists, pedagogues, social workers, health educators, researchers, and others. (Contains 10 references.) (EV)

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Let's talk

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A Dutch community-based
early-childhood care and development support programme

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Let's talk

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Marian Hanrahan
Bert Prinsen

Netherlands Institute of Care and Welfare
MIM Cooperative

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Introduction

This booklet is about the *Mothers Inform Mothers* programme (MIM), a network of local programmes in five provinces in The Netherlands. These programmes are carried out in eight different towns (two large, four medium and two small) in deprived areas. A short overview of the theoretical basis for the programme will be given and the contents of this booklet will touch on the planning, execution and process evaluation activities. The purpose of the booklet is to give information about MIM to an international audience. It is aimed at professionals such as nurses, medical practitioners, developmental psychologists, pedagogues, social workers, health educationalists, researchers and others. Readers will find references used to develop this booklet in *Community Health, Community Care, Community Support*, a book published jointly by the Netherlands Institute of Care and Welfare and the MIM Cooperative (Hanrahan & Prinsen, 1997). In this book you will find a description of early childhood care and development support programs in Ireland, The Netherlands, United Kingdom and the United States of America. Special attention has been given to the development, goal setting and the implementation of these programs, the evaluation research and the role volunteers play in the different programs. MIM is one of the described programs.
A video of the MIM-programme - *The two of us* - is available too.

Setting of the MIM-programme

The Netherlands is a small, densely populated country with a constitutional monarchy. Approximately 15.2 million people live in the country and 3.7 million of these are under the age of 19. The Queen is the formal head of state whilst executive powers are with government. National health policy and overall financial supervision lie with the Ministry of Health, Welfare and Sports. Interest groups are powerful and there is a strong tradition of seeking consensus or compromise. The need for cost containment and improvement of efficiency in health care has resulted in proposals for new structures and a new financing system.

Traditionally, health professionals acted in the expert-care-provider role associated with the medical model. This model has been criticized because of the inherent asymmetrical professional/patient relationship in which recipient dependence is fostered and professionals govern client behaviour. According to the medical model, people are not responsible for solving their own problems but must comply with experts. Hence, many sectors of the health-care system continue to be occupied with cure and treatment, rather than disease prevention and health promotion. However, nursing has changed and community nurses are now embracing new concepts such as community-based models which include social and pedagogical support.

Preventive child health services

The aim of child health care services for pre-school children in The Netherlands can be described as 'the promotion and safeguarding of a healthy, physical, mental and social development of the population of pre-school children, starting

from the parents' personal responsibility, by means of influencing the relevant health determinants, namely physical factors, health behaviour and relevant environmental factors, including the system of care itself.' One objective that can be made operational is 'to promote at an individual and group level, the personal competence and the responsibility of parents with regard to their children, if necessary by advancing their understanding of the health condition and (potential) development of their child and by increasing their competence' and also stimulating health-promoting behaviour (De Winter et al, 1995).The *Mothers Inform Mothers* programme tries to implement this objective.

Preventive child health and welfare services for all children up to the age of 18 have a judicial basis. These services are carried out by municipal or regional health authorities for all school going children, and by community-nursing agencies or general practitioners for all babies and pre-schoolers. Bronfenbrenner (1979) proposed using an ecological model when health educational activities are developed: 'Whether parents can perform effectively in their child-rearing roles within the family depends on role demands, stresses and support emanating from other settings. Parents' evaluation of their own capacity to function, as well as their view of their child, are related to such external factors as flexibility of job schedules, adequacy of child-care arrangements, the presence of neighbours and friends who can help out in large and small emergencies, the quality of health and social services and neighbourhood safety.'

Developing a community based support programme

In the past decade, a wide array of community-based early-childhood development programmes have been designed. They aim to empower adults in their role of parents and prevent injuries, child abuse and/or psychosocial problems in children caused by negative experiences in early childhood. The focus of these programmes is on supporting the family in its own home

environment, and on trying to bring about a change in this environment that can be expected to have a long-term beneficial influence on the child's potential. The philosophy underlying these programmes relates to the concepts of health promotion, social support, and empowerment, that is, the process whereby individuals and communities are able to take more control over their own lives and health and the environmental factors that affect it.

There are many examples of support programmes for parents with children in The Netherlands. They are often adapted from American, British or Israeli programmes such as:

- *Families First*, geared to parents who experience difficulties with school children and teenagers. Over a period of four weeks, a trained worker visits a distressed family for approximately 15 hours a week with the aim of preventing the children from being taken into care.
- *Home Start*, a programme aiming to befriend parents and to give them practical help, friendship and support. The programme helps families with children under six years of age to prevent serious problems from developing through social support, whilst helping to increasing the parents' self-esteem, self-confidence and enhance their social contacts.
- *HIPPY*, geared to supporting and informing migrant parents about the educational needs of their pre-school children. Visiting mothers come into the home of the migrant parents to support them systematically in educating their children. The aim is to increase the responsiveness of the mother to the needs of her young children.

A Dutch-developed activity is video home training, which is geared to parents with communication or mild pedagogical problems. The training helps parents to recognize and analyze their own behaviour when dealing with these problems. The aim is to enhance communication between the parents and their children aged 0 to 18 in such a way that the problems do not

escalate, but rather diminish or get solved. The programmes are focused on parents with different needs. HIPPY and MIM are primary prevention programmes, whilst Home Start and video home training are examples of a secondary prevention programme. Families First is focused on early treatment and can be seen as a tertiary prevention programme. Other local services to support parents are provided by the local crèche, child day care centre, toy library, family resource centre, day-fostering agency, and the experienced-mothers network. An overview of activities and relevant policies is given in $O + O = O^2$; a report on integrated local preventive policies and provision of educational, pedagogical and developmental support services for children and parents at risk (Bakker, Bakker, Van Dijke & Terpstra, 1997).

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High-risk groups

Different high-risk groups have been identified. The first group are parents who do not have their children fully vaccinated. The vaccination rate for the combined Diphtheria, Pertussis, Tetanus Polio vaccine is slowly decreasing since 1984, and there is an ongoing discussion about the lack of evidence-based health promotion endeavours which are carried out as part of the national collective preventive child health and welfare programme. The second group are migrants. Mortality and morbidity figures for Turkish and Moroccan children are found to be higher than those of Asian or Dutch children.

However, a few decades ago, researchers hoped that by finding risk factors they would be able to delineate 'high-risk' groups and consequently would be able to design programmes to improve the prognosis of these groups. This hope turned out to be futile. Further study brought up the conclusion that the effect of the risk factors is not determined by their specific content or severity, but mainly by their number and by the burden they cumulatively impose on the family. An accumulation of various risk problems is necessary to unsettle the process of child rearing. Some examples of these risks are maternal mental-health problems, a lack of spontaneously positive interaction in infancy, low occupational status of the head of the household, lack of family support, low levels of maternal education, disadvantaged minority status, stressful life events, living in inadequate housing conditions and single parenthood.

The support of new parents rearing their children and stimulating their development as part of a health-promotion programme is under scrutiny. Recently, after an extensive empirical study in The Netherlands (Rispens, Hermanns and Meeus, 1996), the investigators concluded that the average Dutch parents are supportive and sensitive to the behaviour and needs of their children. They exert predominantly an authoritative style of controlling the behaviour of children, and only a minority of parents is characterized as chaotic or strictly authoritarian. In

most situations, even when they are not specifically trained or professionally guided, parents seem to find the right answers for the developmental questions about their child, and most children are able to make good use of a wide variety of child-rearing behaviours for their own development.

Why MIM?

When the first plans were being made to develop the MIM-programme in 1990, the well-baby-clinic consultation tended to concentrate on the babies' health and feeding problems rather than developmental and pedagogical matters. MIM has been developed because:

1 practice has shown that inexperienced mothers have many questions concerning the development of their baby for which the community nurse has no time;
2 it was felt that the predominantly working-class mothers experienced difficulty in reaching the predominantly middle-class community nurses. Communication problems hampered the access of these mothers to health education;
3 mothers were given information from many sources, but the result was that they experienced difficulty in making choices which they felt were most appropriate to their own circumstances.

After initially looking at the possibility of translating the Irish *Community Mothers* programme materials, the decision was made to adapt and develop the programme to Dutch circumstances. Whilst having similar aims as the Dublin programme (Hanrahan & Prinsen, 1997; Johnson, Howell & Molloy, 1993), MIM places more emphasis on pedagogical support.

What is MIM?

The *Mothers Inform Mothers* programme is an innovative early-childhood care and development programme and it is based on a synthesis of nursing, pedagogical, and health-promotional knowledge and theories. It is developed as a part of the regular child health and welfare services and it aims to support young parents with parenting, helping them to cope, staying abreast of their child's development and preventing child-rearing problems. The programme also supports the aim of enhancing the ability of women to cope with their newborn baby, of encouraging them to adapt their behaviour after receiving health educational information, increasing the number of women breastfeeding, or making women feel in control of their lives. The main goal is focused on mothers by trying to reinforce their sense of self-esteem and thereby improving their ability to be a self-supporting parent. The programme addresses the same topics as the regular preventive child health and welfare services during the sessions of the well-baby clinic, but these topics are discussed more from a pragmatic angle and placed in a context which is meaningful to the inexperienced mother.

The MIM programme

- The programme focuses on educational support for young inexperienced parents and seeks to improve the effectiveness of anticipatory health educational practices.
- Experienced mothers visit the young mother (programme mother) with a first baby in her own home.
- There is a maximum of 18 home visits over an 18-month period.
- In each home visit, the experienced mother (visiting mother) uses two aids: the home-visiting checklist which acts as a discussion document, and the programme sequence of cartoons.
- A community nurse is the coach of the visiting mothers.

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Stakeholders

The original stakeholders were local experienced mothers who were and still are prepared to support inexperienced mothers who are poor, stressed, or feeling isolated and unsure about their infant's development. They help them to use their own knowledge and instincts in order to reduce health or other risks which may impair their baby's development.

The other stakeholders involved were the nurses, the management of community-nursing agencies and the Netherlands Institute of Care and Welfare. Both inexperienced mothers and the 'Kruiswerk/Gezinszorg Breda'[1] wanted improved health educational services. They both wanted a tailor-made service suited to the needs of mothers and their babies. Senior management of the 'Kruiswerk/Gezinszorg Breda' wished also for an effective and efficient service without loss of quality of care or extra financial input after the developmental phase. Furthermore, the opportunities in preventive child health and welfare practices due to the programme could legitimize their priority setting for services directed at families in need. Nurses were and are interested as an effective service will give them bargaining power with purchasing agencies. In their view, the experienced mothers are well able to support the inexperienced mother in the finding of answers to simple, practical questions or problems. But not all nurses think that way. Some nurses believe that the involvement of experienced mothers in preventive child health services could possibly undermine their professional expertise.

Participants

The programme starts early, ideally just before confinement. All mothers of first children living in the participating areas are offered the programme, but special attention is given to socially disadvantaged groups, members of immigrant communities and

[1] The 'Kruiswerk/Gezinszorg Breda' is a regional community-nursing agency delivering services to frail, handicapped, elderly or ill persons (including children) on a long- or short-term basis. It also provides preventive child health and welfare services for parents with children under school-going age.

children in need[2]. Approximately 30% of all first mothers participate in the programme, which is in line with the set target of the community-nursing agencies.

Communication between inexperienced mother and visiting mother

The inexperienced mother receives monthly visits in her own home, lasting approximately one to two hours. The mothers are often older than 25 years of age and come from a multitude of countries in Europe, Africa and South America. Most have ten years formal education (intermediate and vocational level) and live on the earnings of their spouse, a small percentage are double earners and a slightly smaller percentage live from social welfare payments.

MIM uses experienced mothers to help provide educational support for new parents in learning effective primary health and educational practices. These mothers come from the same target

[2] Children in need are defined as those with disabilities and those whose health or development, in the broadest sense, would be impaired or limited without the provision of such services.

groups that they serve. They are well equipped to answer questions that expectant and new mothers may have. They also have an understanding of what the new mothers are going through. An experienced mother of twins, for example, is matched with an inexperienced mother of twins. Mothers who breastfeed their babies, or mothers with a baby suffering from a severe allergy or a baby born prematurely, are matched the same way.

These mothers use cheaply produced cartoons depicting either different scenes, or the choices that can be made about a specific topic. A discussion about the contents of a cartoon may act as a start for exploring the mother's attitude, knowledge or behaviour in relation to the advice she has received from different sources. Visiting mothers adapt the MIM-materials to suit the individual mother they visit. Both live in the same neighbourhood and usually have similar backgrounds. The experienced mother will use her own standards and experience as a mother to support and assist the young mother. In doing so, she will give as little advice as possible. Rather, she will support the young mother in finding her own answers to day-to-day questions and in resolving problems when they arise.

To help them plan their visits, the experienced mothers use a discussion paper which they are free to use during the visit, or which they use to document their visit afterwards. The inexperienced mother will get this document at the next visit. In this way, the inexperienced mother has a record of all developments which take place during the 18 months of the programme.

What is the role of nurses?

The activities of the well-baby-clinic team and the role of nurses working in the services are traditionally multidisciplinary. The process of promoting, monitoring and securing the health and welfare of the child and its parents involves the expertise of medical practitioners and community nurses in addition to

nutritionists and early-education specialists. Nurses have proved to fulfil an important role as observers of the combined mental and physical aspects of health. In MIM the traditional role of community nurses has undergone some significant changes. Nursing has changed in the past ten years and community nurses are now embracing new concepts such as community-based models which include social support. Nurses have to place their trust in volunteers who befriend and support inexperienced mothers in making up their own mind whether to act upon advice from the well-baby clinic or others in order to enhance the development of their babies. The visiting mothers make comparisons and evaluate themselves on a regular basis with questions on how they are doing. Instead of giving advice and information about the development of very young babies to inexperienced mothers, they are engaged in supporting and facilitating community networks of experienced mothers as the coordinator of the programme. The assistance provided by nurses is best thought of as surrogate support, extending the support available in the client's network and replacing that which is not available. The nurses stimulate the work of the experienced mothers in supporting and enhancing the locus of control of the inexperienced mothers.

Community nurse as a MIM-coordinator in Breda

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The MIM-coordinator

At each programme site, the coordinator participates in the programme as one of the experienced mothers. There are eleven MIM-coordinators currently active, some on a part-time basis as they are also engaged in the regular child health services. All nurses have a bachelor degree in nursing (or equivalent) and more than three years practical experience after graduation. The nurses are employed by the regional community-nursing agency. The coordinator is responsible for recruiting both experienced and inexperienced mothers according to educational or other significant common background variables. She prepares the volunteers for their work and matches the inexperienced mothers to the experienced mothers. She facilitates the monthly group meetings organized by the experienced mothers themselves. These meetings last usually one and a half to two hours. During these meetings, experienced mothers share their experiences and discuss ways and means of enhancing programme proceedings. They also share conflicting advice or other signals they may have encountered during the home visits from the inexperienced mothers' visit to the well-baby clinic. Other tasks performed by the coordinators are assuring the ongoing quality of care, representing the programme at workshops, seminars or conferences and having regular meetings with the members of the well-baby-clinic teams. Usually, representation of the programme is done in cooperation with one of the child-health-care service managers and in combination with one of the experienced mothers.

Theoretical basis of MIM

The basic concepts underlying the MIM programme are models of nursing, social support, social learning and social comparison, empowerment and health promotion.

Nursing models

The nursing concepts used when developing the programme were mainly based on the work of King, Neuman and Orem (in: Arets & Slevin, 1995). King developed a model of goal realization. In this model, interaction between nurse and individual is one of the key elements. This interaction and the theory of goal realization which is closely connected to it is an open-system approach. According to King, there are three interactive systems that are essential to nursing. These are personal, interpersonal and social systems, jointly determining and achieving goals by way of perception, communication, interaction, and transaction. After nurse and individual have become acquainted, it is important that they each verbalize and check their perceptions. Together they can try to determine the goals via communication and interaction.

Neuman considers individuals, groups (meaning the closer family circle in particular), and the community from various perspectives and in continuous interaction with stress in that environment. The environment plays a central role in Neumanís model with both external and internal components which continuously influence the person. At the same time, the environment is influenced by the person, which results in the interaction that plays such an important part in her model.

The central theme in Orem's conceptual model is self-care, and the notion of the self-care deficit, which is closely related to it. Orem asserts that nursing intervention is legitimate when an

individual has a self-care deficit and is therefore insufficiently capable of providing the therapeutically required self-care. In essence, the nurse and the individual work together, the nurse always promoting and encouraging the individual's involvement and maximum independence.

Social support

Most support of inexperienced parents is supplied by neighbours, family members, friends and a host of others. When these informal services are not enough, professional services are offered by volunteer groups, community centres, or private enterprise. Social support has captured the attention of policy makers in the health and social services fields because mutual aid and informal care are indispensable complements to the programme provided by statutory social services and community-nursing agencies. Strengthening of social networks and social support is pivotal in a health promotion strategy. Social support is seen as a function of personal relations and is, in conventional terms, assistance given by lay persons who are part of one's social network, rather than by nurses. More specifically, it is emotional, instrumental, informational and appraisal assistance provided by family, friends, neighbours, colleagues and self-help mutual-aid groups which can have positive and negative influence on the psychological and physical well-being of its recipients. Without the help and emotional aid given by the community's informal support systems, institutional resources would be overwhelmed, and indicators of health and well-being would decline precipitously.

Pedagogical and psychological support

MIM has also a pedagogical dimension based on social learning theory, attachment theory and a transactional model. In MIM this pedagogical dimension is linked with social comparison. Social comparison is a theoretical basis for determining whether people are similar in terms of health status, illness severity, stress

mastery or coping stage. People will make upward comparisons with those coping better than they are (who serve as role models) and downward comparisons to enhance self-esteem and protection.

TROOSTEN HELPT ALTIJD, OOK AL STOPT HET HUILEN NIET DIRECT
heb je kramp?
heb je poep in je broek?
komt er een tand?
NA VERLOOP VAN TIJD ONTDEK JE WAAROM DE BABY HUILT
als hij op schoot zit, is het goed
her ben ik al
TROOSTEN GEEFT JE KIND EEN GEVOEL VAN VEILIGHEID EN VERTROUWEN
EEN SPEEN, EEN KNUFFEL EN MUZIEKJE HELPEN SOMS ALS HET EVEN MOEILIJK IS
ALS NIETS MEER HELPT, MOET JE ER GEWOON EVEN TUSSEN UIT
zo, hoe ging het?

Example of one of the 48 cartoons

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Social comparison can be defined as people's tendency to evaluate themselves and to elicit information about their characteristics, behaviour, opinions, and abilities through comparison with similar others. Social networks influence how their members seek help from nurses or other professionals, and use their services by buffering experiences of stress, thereby eliminating the need for help, providing support and services, by acting as screening and referral agents, and by transmitting values, attitudes and norms about seeking help. Lay networks also enhance, complement, or serve as alternatives to professional services.

Social learning theory approaches the explanation of human behaviour in terms of continuous reciprocal interaction between cognitive, behavioural and environmental determinants. Within the process of reciprocal determinism lies the opportunity for people to influence their destiny as well as the limits of self-direction. This concept of human functioning neither casts people into the role of powerless objects controlled by environmental forces, nor free agents who can become whatever they choose. Both people and their environment are reciprocal determinants of each other. Social competence and skills necessary for forming and maintaining relationships, including social problem-solving skills, empathy and comfort in intimate relationships, are qualities of a self-actualizing person. People who are low in perceived social support have poorer social skills and are not able to initiate or maintain relationships or communicate their needs. There is a general consensus among researchers on child development and developmental psychopathology that child rearing is a transactional process. Within this process, there is an ongoing interaction between children and educators characterized by mutual influencing of each others development.

Health promotion and empowerment

As in health promotion in general, community-based early-childhood and development programmes are working for and with individuals rather than on them, in the setting of everyday life. As knowledge is gained about the relationship between personal behaviour and environmental conditions, and risks to health, so has there been a growth in understanding the potential contribution of health education in supporting the health of very young children. Intersectoral collaboration and community participation are essential factors. Parents are seen as the experts on their own child and are encouraged to solve their own problems in child rearing. The strategy of organizing women to reach out to other women builds on the strengths of local communities and their self-help traditions. The active and decisive role that experienced and inexperienced mothers play in the programme creates a basis of trust for the programme among the target groups. From the process evaluation we know that the mothers see the programme as their own and a discovery of 'being able to do more than I thought possible.' The result of this is empowerment: people regaining control over their own lives.

Implementing MIM within an organization

To facilitate the start of each programme in a local area, the community-nursing agency seeks funds from the local municipality, charitable foundations and/or insurance companies. The preparatory period for implementing MIM in a regional community-nursing and home-care agency usually lasts one year. Discussions starting at management level continuing up to floor level take place to prepare activities prior to the actual start of the programme. Special attention is given to the role and function of the nurse who coordinates the programme locally. This nurse is specialized in child health and welfare and a decision has to be made on whether or not the coordinator is a member of the well-baby-clinic team. When a mother is seen as an expert, the cooperation, participation and partnership between her and the professional employees (doctors and nurses) needs to be addressed. This means discussions on different levels in the organization and guidelines for practice. When this preparation stage is finished the project can start in earnest. National professional support to implement and support the coordinator is given by a pedagogue (developmental psychologist) and a health educationalist who are seconded to the programme from the Netherlands Institute of Care and Welfare and the MIM Cooperative.

Evaluating MIM

During 1996, a process evaluation was carried out in all programme locations and compared with the results of a previous action-research project which was carried out simultaneously with the developmental phase of the programme. The experienced mothers were asked what motivated them to become a volunteer in the programme. They answered differently such as: sharing one's own experiences with others, helping to make contact in a new neighbourhood, preventing a feeling of insecurity after having your baby or preventing a feeling of loneliness and depression. They indicated that the number of visits to inexperienced mothers should be limited to not more than three per month, because 'I have a part-time job,' 'I need time at home,' 'I need time for adult education activities,' or 'I am engaged in other volunteer activities.' The experienced mothers all work under the aegis of the volunteers' charter in which all privileges, insurance, rules and regulations are outlined. All their expenses are reimbursed.

Reasons for participation as a visiting mother

'In working in the programme, I helped other mothers to enjoy their baby.'

'Through the programme I give support, and make them (the inexperienced mothers) trust their own intuition.'

'I was able to help young mothers to make social contacts.'

'When I had my baby, I wanted to talk about it and someone listened: I like to give the same opportunity to other mothers.'

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'One of the visiting mothers said: "I was too proud to avail of the programme when I had my baby, but with hindsight I was sorry. Since then, I learned that my experiences could be of help to young inexperienced mothers."'

'I was insecure when I had my first baby and I wish now that this service was available at the time.'

'I am happy to participate and be part of the programme and the social network. It helped to raise my self-esteem.'

'When I had my baby I was extremely lonely, notwithstanding my efforts to expand my circle of social contacts. Working in the programme has changed that.'

'I started with the programme because I felt trapped within the four walls of my house. And participating in the programme made me go out and meet people.'

'I felt that with working in the programme I was very useful again.'

In the action-research study, emphasis was on the qualitative evaluation of the programme. This would make it possible to use its results to improve the programme's implementation by adjusting the content, the tools employed and the methodology of various parts of the programme. The outcome is a transferable programme for support in child rearing and health promotion. The results of the study were instrumental in changing the contents and layout of the programme.

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Evaluations at programme locations

To facilitate the start of each programme at a different location, the community-nursing agency looked for money from local authorities, charitable foundations or insurance companies. At present (autumn 1998) there are four locations in place: Breda, Dordrecht, Sneek and Uden. In Amsterdam, Zwolle, Hengelo and Oss the programme has started recently.

Process evaluations from the established locations showed the following results:

- Monthly 91 experienced mothers visit 224 inexperienced mothers
- Inexperienced mothers from lower and upper income brackets were initially less successfully reached than those in the middle income brackets. This has changed over time with mothers from different social backgrounds participating in the programme.
- The largest groups of inexperienced mothers are Dutch. However, approximately 23% of women are foreign. They are migrant workers from Turkey and Morocco and fugitives and asylum-seekers from predominately a variety of non-European countries (Africa and Asia), and from the former Republic of Yougoslavia.
- The necessary money comes from a variety of sources. Breda has a long established programme and has funded the continuance by using efficiency measures within the preventive child health budget. Dordrecht, Zwolle and Hengelo are each receiving a subsidy from their local municipal authority. Sneek is using a combination of funding: a charitable foundation and

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the local authority. Uden has re-arranged budget parameters with permission from the regional health insurer. Indications are present that after the initial phase of establishing the local programme finance may be found by using efficiency measures and by participating in locally funded child health and welfare networks.

Current research activities

Evaluating community-based interventions using appropriate techniques is difficult and complex, because the research process does not always fit the practice under scrutiny. The problems to deal with are known. There are problems with research design and also problems in studying the effectiveness of community-based childhood care and development programmes. The poor quality of evaluation in this field has been an important obstacle to better interventions and wider acknowledgement of the importance of health education in supporting the health, welfare and development of the very young.

Traditional research models are based on the wish to discover, predict and control natural phenomena. It is a process of reductionism, which involves breaking down components of a complex world into distinct parts, which is nearly impossible when dealing with individuals living at home, meeting people and receiving information from all sides. According to Vimpani et al (1996) approaches based on a variety of models have been initiated and evaluated in the last ten years. These were a parent-education model, a public-health model, a social-support model, a mental-health model and an interaction-attachment model. Overlaps among these models exist. For example, the public-health model includes social support and parenting as programme components. MIM is an example of a synthesis of an ecological, community-health and interaction-attachment model to facilitate health promotion and pedagogical activities.

Since 1998 an evaluation of the programme is in progress. It explores the question 'What is the efficacy of the programme?' Evaluation will focus on nutrition (both mother & baby), dental health (baby) and mental health (mother). It will also establish the extent to which the intervention has reduced differences in socio-economic groups. The effect variables shall take into account the expected time lags between intervention and effect. When the effects are established it is imperative to determine the necessary activities prior to implementing the programme efficiently and effectively at new locations. An experimental design (community intervention trail) involving three groups is used. Due to practical constraints it is not possible to allocate mothers and babies randomly to these groups. Group one will be the intervention group. There are two comparison groups. The first groups are inexperienced mothers from the same location as the intervention mothers (Breda, Dordrecht, Sneek and Uden). The second and third group are mothers from different locations (Almelo and Den Bosch). All mothers are invited to use their local community health centre.

Community-based prevention programmes involve an ongoing process of decision making which requires a flow of regular inputs rather then one intervention - evaluation situation. Therefore, a combination of research techniques is required. As far as the measurement of health status, measuring perceived and actually received social support, knowledge and attitudes is concerned, scientifically validated instruments will be used. To reach non-Dutch-speaking participants in the programmes, it is envisaged using migrant health educational aides who will help the inexperienced mothers with answering the questions. These aides will be trained for their task so that their involvement will not influence the mothers answering the questionnaire(s). Where appropriate, routinely gathered information about the mothers and their babies will be noted on a research schedule.

The first results of the evaluation will be published in 1999.

In preparing research, it was interesting to note that when comparing the MIM-participants with participants in similar programmes in Europe and the United States of America, the age profile in MIM is much higher. This is partly due to the lack of teenage pregnancies in The Netherlands. The teenage mothers that are found are often married, with one or both parents born outside the country. Also in absolute numbers, the choice of when to start a family is often made after age 25. The average age for having a first baby is 29. Another difference with international programmes is the exclusion of the prevention of child abuse as one of the items evaluated. Child abuse will not be an item to be measured. There are two reasons for this. Firstly, the national guidelines on the detection of child abuse are not fully implemented by all Dutch community-nursing agencies. Secondly, a conscious decision was made not to include the prevention of child abuse as one of the explicit objectives in the programme, but rather to enhance circumstances for the mothers so that they are conducive to the development of the children. In this way no labelling or stigma is attached to participating in the programme.

Strengths and weaknesses of MIM

After discussing the programme with managers and staff of community-nursing agencies, we have identified the main strengths and weaknesses of MIM (Hanrahan & Prinsen, 1997). The strengths in the programme are as follows:

- It has been developed in partnership with the target group. Disadvantaged mothers were participating at the developmental stage of the programme.
- It has been developed as a potential integral part of the child-health-care service, so there will be no lack of continuity.
- Its potential of reaching the target group is high.
- The action research experiences and the results of the process evaluations are encouraging.

- MIM may have the effect of lowering socio-economic health differences and it intervenes with mother's/baby's health and welfare determinants.

There are also some weaknesses and problems that have to be overcome in order to make the programme an integral part of the statutory preventive child health package.

- Social paediatricians have a strong strategic position and there is not much body of knowledge from the nursing profession to warrant face value acceptance.
- Epidemiological research or an evaluation of the effects of the programme has not yet been carried out. International research results concerning early-childhood care and development support programmes are available (Olds and Kitzman, 1990; Johnson, Howell and Molloy, 1993).
- No study on the cost-effectiveness of the programme has been carried out.
- The financial basis of the programme within current budgets of health-care agencies is uncertain. Discussions on the positioning of the programme are ongoing due to the presence of some pedagogical components in it. At present, positioning of the programme within preventive child-health-care is being advocated by the participating organizations. Preventive health-care is paid through general-health contributions and through child-care activities which are part of the welfare system and are funded by local authorities. In order to receive additional money to pay for the starting-up phase of MIM in a new organization, the programme has to compete with many other projects and activities.
- Reaching mothers living in multi-problem circumstances is going at a slow pace and is very time consuming. Getting results within a relatively short time is difficult.

MIM-type programmes empower parents in such a way that they are not only active with their own children, but also starting

activities in order to change the physical environment in which they live. In MIM we see multiple outcomes and it is targeted at many beneficiary groups. Empowered parents may ask for specific health services, improved educational facilities and income support beyond what is currently the norm.
MIM is developed as an additional, but potentially integral, part of the regular statutory parents and pre-school children's health services in The Netherlands. It is envisaged that its effectiveness will be tested, so that with these results the decision can be made to fund the programme as an integral part of the national parent-child care and health services. As a result of these findings and innovations in child-health care, the programme might be incorporated in the statutory services by the year 2000.

More information

In this booklet, an overview has been given on the Dutch *Mothers Inform Mothers* programme and some background information has been provided. A video of the MIM-programme is available (1998). MIM focuses on community-based early-childhood development in its broadest sense. This type of programme is concerned with restoring power to the community and reducing excessive control by others over people's daily lives. It is also concerned with reaching back to our roots in holistic care. International examples of community-based support programmes are described in *Community Health, Community Care and Community Support* which is available from the Netherlands Institute of Care and Welfare in Utrecht.

More information about the MIM-programme is available at the Netherlands Institute of Care and Welfare and the Dutch MIM Cooperative, P.O. Box 19152, 3501 Utrecht, The Netherlands, telephone (0031) 30 230 63 11, fax (0031) 30 231 96 41, E-mail: B.Prinsen@nizw.nl.

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The Netherlands Institute of Care and Welfare / NIZW

The Netherlands Institute of Care and Welfare / NIZW is an independent institute for renewal and improvement that renders services to organizations and professionals in the care and welfare sector offering assistance with regard to anticipating to new developments and safeguarding the quality of the services. The NIZW works in close cooperation with these organizations to develop methods, organise work conferences, design quality improving instruments, and seek adequate forms of cooperation between the organizations. The results and experiences are subsequently published in books and newsletters and presented through conferences and videos.
In addition to renewal and improvement, the institute aims at strengthening the sector as a whole, a task entrusted primarily to the Centre for Professional and Vocational Training Affairs and the Information Centre of Care and Welfare. The International Centre offers its intermediary and supporting services for cooperation on international levels.

NIZW's activities focus on various fields of the sector, including nursery activities, youth welfare work, social work, services for the elderly, social-cultural work, crisis centres, nursing homes, home care and assistance to the physically or mentally handicapped.
All in all, more than 400,000 professionals and many volunteers are active in this sector. The NIZW seeks to render services to this segment of the workforce by means of their products and, in addition to this, the NIZW increasingly offers its information to the actual consumers of services in the sector.

The MIM Cooperative

The MIM Cooperative is the existing partnership of regional community-nursing agencies and the Netherlands Institute of Care and Welfare. The main goal of the cooperative is the large-scale implementation of the Dutch programme *Mothers Inform Mothers*. The MIM Cooperative offers its (potential) partners professional support, programme development and evaluation. Activities like publishing, the organization of conferences and information also belong to the regular tasks. In the next years, more nursing agencies will probably be partners in this national network.

This booklet is about the *Mothers Inform Mothers* programme (MIM), a network of local, community-based early-childhood care and development support programmes in The Netherlands. It also contains a short overview of the theoretical basis for the programme - from health promotion to social support, nursing, and community organization - and it touches on the planning, execution and process evaluation activities. The contents are useful to public-health officials, nurses, social workers, developmental psychologists and pedagogues who are planning projects aiming to reduce inequalities in health, or to reduce environmental risks in disadvantaged areas.

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